Somerset Health
your wellness journey

ADDITIONAL INFORMATION FORM

CLIENT'S SUPPORTS

Other Contact Person/s*:	Name: Phone: Email: Address: Name: Phone: Email: Address:
Best contact person for appointments?	
Informal Supports? - Family - Friends - Community Members	
Formal Supports?	☐ SIL, STA, MTA or SDA Accommodation Provider ☐ Support Worker ☐ NDIS Support Coordinator/ CoS ☐ Disability Advocate ☐ Lawyer ☐ Meal Delivery ☐ Community Access Provider ☐ Supported Employment (e.g. TAFE)
Does the client go to school?	☐ Yes ☐ No School Name: Grade / Year Level: Main Teacher/s: Other School Supports (e.g., teacher aides, Aboriginal liaison officer (ALO) etc: ☐ Yes ☐ No

	Does your child have an individual education plan (IEP): ☐ Yes ☐ No
Has the client previously seen an occupational therapist (OT)?	☐ Yes ☐ No
	Who:
	Where:
	How long:
	What for:
Is the client currently seeing any other health professionals?	☐ Physiotherapist ☐ Psychologist ☐ Psychiatrist ☐ Mental Health Nurse ☐ Speech Pathologist ☐ Dietitian ☐ Exercise Physiologist ☐ Aboriginal Health Practitioner
Has the client been engaged with any of the above supports?	☐ Yes ☐ No
	Who:
	Where:
	How long:
	What for:

**This may include key family or interpreter contacts that have known the client for a long time. Key contacts may include direct family members, partners, carers, support workers, health workers, GP, or disability advocate.*

MEDICAL INFORMATION

Medical History:	
Recent Hospital Admissions:	☐ Yes* ☐ No
	Date of Discharge:

**If yes and the client has recently been in hospital, please attach hospital discharge summaries.*

Please attach any supporting documentation that will help with reviewing the new OT referral, including:

- Medical reports
- Allied health reports
- NDIS participant goals

CLIENT ENGAGEMENT ADVICE

Where is the best location to see the client?	☐ Home ☐ Other family member's home ☐ Carer's home ☐ Local support organisation office ☐ Local Health Clinic / Hospital ☐ Work ☐ Day Centre ☐ Aged Care Facility
Does the client have any specific interests?	
What are the client's strengths?	
Are there any activities the client dislikes?	

CLIENT'S FUNCTION AND LIFESTYLE

Living Arrangement:	☐ Government Housing ☐ Owned /Mortgage ☐ Rental ☐ Aged Care Facility ☐ Hostel ☐ Homeless ☐ House ☐ Unit ☐ Ground Level / Flat ☐ Elevated / Multiple Storeys

Does the client use / need mobility aids?	☐ Yes ☐ No *If yes, what do they use?* ☐ Walking Stick ☐ Wheelchair ☐ Four-Wheeled Walker ☐ Mobility Scooter ☐ Powered Wheelchair ☐ Other:
Is the client deaf or have a hearing impairment?	☐ Yes ☐ No
Is the client blind or have a vision impairment?	☐ Yes ☐ No

CLIENT RISKS

Home Environment:	Is the client safe to be seen at their home? ☐ Yes ☐ No Are there any dangerous dogs or animals at the client's home? ☐ Yes ☐ No
Does the client have a mental health care plan (MHCP)?	☐ Yes* ☐ No
Does the client have any behaviours of concern?	☐ Yes ☐ No *If yes, what are they?* ☐ Aggression (verbal or physical) ☐ Withdrawal ☐ Self-neglect ☐ Self-harming or suicidal ☐ Repetitive behaviour ☐ Wandering ☐ Inappropriate sexual behaviour ☐ Inappropriate social behaviour

Does the client have a known criminal history?	☐ Yes ☐ No
Does the client have any active legal matters, such as court orders?	☐ Yes ☐ No
Does the client have a suicidal history?	☐ Yes ☐ No
Is the client known to hold weapons?	☐ Yes ☐ No
Is the client known to use illicit drugs or alcohol excessively?	☐ Yes ☐ No

*If yes, please provide a copy of the MHCP.

OTHER INFORMATION

Is there anything else Somerset Health should know about the client?	

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